Prenatal/Postpartum Case Management Plan for CIS Maternal Child & Family Health Services

☐ Initial ☐ Renewal: *If renewal, STOP date of most recent Case Management Plan* __/__/___

Name _____**DOB** _____ **EDD** _____ **Medicaid #**_____

Address_____ **Phone** _____ **Health Provider**_____

Lead CM Agency:_____ Medicaid Provider #: _____

Collaborating CM Agency: _____ Medicaid Provider #:_____

→ Is a family member receiving Medicaid-funded home-based and/or Case Management Services from another program? ___Yes ____No

If yes, check all that apply: ____ECFMH ____DDMHS ____Part C ____Family Services ____Economic Services_____Other (please specify)

If yes, CM Plan below must show that CM services requested do not duplicate Medicaid–funded services of other programs.

ASSESSMENT - If renewal, include progress made under prior plan

Family Strengths:

Family Risks:

- ☐ Significant medical/OB problems (PTL, OB/GYN risks, chronic disease, dental disease)
- ☐ Significant nutritional deficits (inadequate weight gain, severe n/v, eating disorder)
- ☐ Age 17 or under)
- ☐ Mental illness/depression (currently impacts daily functioning)
- ☐ Significant cognitive delays/developmental disabilities
- ☐ Homeless; unsafe housing
- ☐ Tobacco/alcohol/drug abuse (>1/2 ppd smoker; current use of alcohol, prescription or street drugs)
- ☐ Isolation/no community resources; absence of social supports
- ☐ Client victim of child abuse/neglect (as a child; unresolved issues)
- ☐ Client child abuse/neglect of a previous child
- ☐ Domestic abuse/violence (current experience or threat of)
- ☐ Other _____

PLAN - Not to exceed six month time period

Short Term Goals

Goal (Objective)	Action Plan (Activities)
1	1 a)
	b)
2	2 a)
	b)
3	3 a)
	b)

Long Term Goals: CIS: 1) Pregnant/postpartum women and young children thrive: a) receives adequate on-going prenatal care, beginning in the first trimester; b) enrolls into WIC; c) gains adequate weight during pregnancy; d) seeks help/is referred to treatment resources for alcohol and drug use, including tobacco; e) reduces child abuse/neglect; f) receives appropriate information about community resources

CM Agency Use Only				**VDH Use Only**
CM Time Period Requested:				CM Time Period Approved:
Start / / Stop / / (# of weeks)				Start: / / Stop: / / (# of wks) ____
√	**HBK&F Procedure Code** (**MP**-Masters prepared **LR** – low risk **HR** – high risk)	**HHA or PCC (Circle)**	**# of Visits Requested**	**# of Visits Approved:**
	T1022-HD-U7 (RN/MP/HR)	HHA Only		
	S9445-HD-U7 (FSW/HR)	HHA PCC		
	S9445-HD-U6 (MP-FSW/HR)	HHA PCC		
CM Signature: Date Signed: ___/___/___				Date Data-Entered: ___/___/___ **VDH/MCH Coordinator:**
Collaborating CM Signature:				___ Approve ___ Approve w/ change ___ Deny